John C. Longest Student Health Center
Travel Clinic Work Sheet
P.O. Box 6338; Mississippi State, MS 39762
662-325-8888 (fax); 662-325-7539 (phone)
Email health@msstate.edu
www.health.msstate.edu

IMMUNIZATION RECORD MUST BE ATTACHED PRIOR TO SCHEDULING AN APPOINTMENT. PLEASE CALL 662 325-7539 IF YOU HAVE ANY QUESTIONS.

Traveler: For us to best serve you this form needs to be filled out completely and submitted six to eight weeks before your departure.

Name: _____**SSN:** _____/_____/_____

Date of Birth: _____/_____/_____ ******Any child under 18 years of age must be accompanied by a parent/guardian.***

Itinerary: Departure Date: _____/_____/_____ **Return Date:** _____/____/____

Country	**Length of Stay in country (weeks)**	**Cities**	**Rural**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

High Altitudes: Yes No Pregnant: Yes No

MEDICAL PROBLEMS:

_____
_____
_____
_____

CURRENT MEDICATIONS:

_____
_____
_____
_____

ALLERGIES:

_____

REASON FOR TRAVEL:

_____

IMMUNIZATION HISTORY:

******************Please provide a copy of your immunization record(s). ***************************
We need your immunization history in order to prescribe the recommended/required vaccinations.

IMMUNIZATION RECORD MUST BE ATTACHED PRIOR TO SCHEDULING AN APPOINTMENT. PLEASE CALL 662 325-7539 IF YOU HAVE ANY QUESTIONS.

Financial Arrangements

Patients are expected to pay for immunizations, medications, and vaccine administration charges. A charge for provider consultation will also be assessed ($25 students/$40 non-students).

TRAVEL ONLY patients are required to pay SHC at the time of service. SHC patients and MSU employees and students may choose to pay the balance after that insurance has paid. Some health insurance plans will pay for these services. SHC will file the charges to insurance. Any insurance proceeds will be refunded to the patient. Charges unpaid by insurance are the responsibility of the patient to pay.

NOTE: Yellow Fever and Encephalitis vaccines (among others) are not paid by most insurance plans, so patients can expect to pay for these vaccines. You may be advised to check with your insurance plan to be aware of what items are paid.

I have read and acknowledge the financial terms above and agree to pay SHC for the charges related to this travel clinic.

Name (print) _____ **Signature** _____

Date: _____/_____/_____ **Phone (_____)** _____

Responsibilities of the Traveler

Seeking and Following Pre-Travel Health Advice

Obtaining pre-travel health care and advice from a clinician familiar with travel is an important step in preparing to travel internationally. Ideally, this visit should take place 4-6 weeks before travel, but even getting a consultation in the week before travel can be of value. The pre-travel visit includes a discussion of immunizations, prophylactic medications (such as anti-malaria drugs), and specific health advice for preventing and treating traveler's diarrhea and other illnesses the traveler may encounter.

Please have only one clinician do your entire travel clinic as there are certain immunizations that require a waiting period before you can receive other injections.

Submit a list of current immunizations when requesting an appointment.

Health History Center
Mississippi State University

Longest Student Health

Last Name First Middle Social Security Number Date of Birth

(CIRCLE AND/OR FILL IN THE APPROPRIATE BLANK)

FAMILY HISTORY

Relationship	Age	Health (Good, Fair, Poor)			Occupation	Age at Death	Cause of Death
Father	_____	G	F	P	_____	_____	_____
Mother	_____	G	F	P	_____	_____	_____
Brother	_____	G	F	P	_____	_____	_____
Sister	_____	G	F	P	_____	_____	_____
Brother	_____	G	F	P	_____	_____	_____
Sister	_____	G	F	P	_____	_____	_____

FAMILY ILLNESS

Disease	Relationship(Grandparent, Parent, Brother, Sister, Other)				
Diabetes Mellitus	G	P	B	S	O
Kidney Disorders	G	P	B	S	O
Heart Disease before age 45	G	P	B	S	O
Asthma	G	P	B	S	O
Cancer	G	P	B	S	O
Other Heritable Disorders	G	P	B	S	O
High Blood Pressure	G	P	B	S	O

SOCIAL HISTORY

Alcohol Usage (circle one) Never 1/year 1/month 1/week 1/day **Drug Use:** (circle one) Yes No
(One drink equals: 4 oz. wine, 12 oz. beer, or 1 oz. liquor)

Tobacco
_____ I don=t smoke, dip or chew.
I smoke _____ cigarettes/day for _____ years.
_____ pipes/day for _____ years.
_____ cigars/day for _____ years
I dip _____ cans/week for _____ years.
I chew _____ pouches/week for _____ years.
I quit _____ years ago.

Seatbelts
I use seatbelts _____% of the time while riding or driving.

Helmets
I use helmets _____% of the time while skating, cycles, or ATVs.

Exercise
I exercise enough to sweat and breathe hard _____ times/week

REVIEW OF SYSTEMS (check those which apply to you)

Allergies
_____ Penicillin
_____ Aspirins
_____ Sulfa
_____ Codeine
_____ Other _____

Nervous System
_____ Bulimia or Anorexia
_____ Head Trauma (concussion)
_____ Headaches
_____ Depression

Operative Procedures
_____ Tonsillectomy _____ +/- Adenoidectomy
_____ Appendectomy
_____ Wisdom Teeth Extractions
_____ Hernia Repair
_____ Knee Surgery, Left or Right
_____ Other _____

Infectious Diseases
_____ Chicken Pox
_____ Mononucleosis

Cardiovascular System
_____ High Blood Pressure

Last Pap Smear _____

Current Medications: _____

John C. Longest Student Health Center **Demographics** **P O Box 6338**
Phone 662.325.2431 Fax 662.325.8888 **Mississippi State, MS 39762**

Name: _____ **SSN:** _____ **MSU ID**: _____ **Net ID**: _____ **Date of Birth:** _____

Local Address:_____
Street City State Zip

Permanent Address:_____ **Sex:** Male Female

Marital Status: Single Married Divorced **Cell Phone #**: (____)_____ **Local Phone #:** (_____)_____

In an emergency please contact:

_____
Last Name First Middle Address City State Zip

Home Phone: (_____)_____ **Work Phone:** (_____)_____ **Relationship:** _____

CONSENT TO TREAT

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Patient Signature: _____ Date _____

INSURANCE POLICY HOLDER (Person who owns policy)

_____ **Male Female Married Single Divorced**
Last Name First Middle Initial

_____ **SSN:** _____
Mailing Address City State Zip

Date of Birth: _____/_____/_____ **Home Phone** (_____)_____ **Work Phone** (_____)_____

Relationship to Patient: Self Spouse Parent **Employer/School** _____

INSURANCE INFORMATION

_____
Insurance Company Name Mailing Address City State Zip

_____ _____ _____/_____
Group Name/Number Insurance ID # Policy Date from to

WAIVER OF THE STATE LAW FOR RELEASE OF INFORMATION - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed: _____ Date: _____

AUTHORIZATION TO PAY PHYSICIAN – I understand that charges are due at time service is rendered. However, if doctor approves, I authorize any insurance benefits be paid to physician.

Signed: _____ Date: _____

Longest Student Health Center Privacy Official, Stanthia Oakley 662.325.0706

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided (see following pages) with the HIPAA Notice of Privacy Practices revision April 14, 2003 of Longest Student Health Center.

Name: _____ **DOB** _____ **SS**N: _____ Med Rec #: _____
Please Print

Signature of Patient: _____ Date: _____

For Personal Representative of the Patient (if applicable)

Print Name of Person Representative: _____

Describe Personal Representative Relationship: (parent, guardian, etc)_____

Signature of Personal Representative: _____ Date: _____

FOR PRACTICE USE ONLY

_____

_____

Signature of Practice Employee:_____ Date: _____

Revision April 14, 2003

If you are a new patient, please read the following and complete the receipt on page 4. Thank you.

HIPAA NOTICE OF PROVIDER PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Mississippi State University's Longest Student Health Center must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your medical record. In general, when we release your health information, we must release only the information needed to achieve the purpose of the use or disclosure. Your personal health information will be available for release to you, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices a revised notice will be available upon request or at www.health.msstate.edu/privacy.

We can use your health information for the following purposes:

Treatment ***Our clinicians may review your medical record to determine which treatment best addresses your health care needs. For example: Patients with chronic sore throat; the clinician may review your chart to determine your treatment, medication or surgery.***

Payment ***In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis and the treatment provided to you. This requires that we pass this information to an insurer in order to receive payment for your medical bills.***

For example: We will submit to your insurer your name, date of birth, address, social security number, diagnosis and treatment received to receive payment for services you receive.

Health Care Operations ***We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. For example: our clinicians review patient charts to determine the most effective, cost efficient treatment for specific diagnoses.***

In addition, for appointment reminders, we may look at your medical record to determine the date and time of your next appointment with us and communicate to you this information. We may also look at your medical information and decide that another treatment or new service we offer might interest you. For example: we may contact patients with tobacco use disorder to notify them that we have a tobacco use cessation program.

Without your authorization, we can use your health information for the following purposes:

As required or permitted by law. Sometimes we are required to report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example: We may have to report abuse, neglect, domestic violence or certain physical injuries or respond to a court order.

For public health activities: We may be required to report your health information to authorities to help prevent or control disease, injury or disability. This may include records pertaining to certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child neglect or abuse. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety. For example: Should you develop a contagious disease, such as measles, we may need to notify the proper officials.

For health oversight activities: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline, or license those who work in the health care system or for government benefit programs.

For activities related to death: We may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

To avoid a serious threat to health or safety: As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to you or the public's health or safety.

For military, national security, or incarceration/law enforcement custody. If you are involved with the military, national security, or intelligence activities, you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

To those involved with your care or payment of your care. If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, we may release specific health information (your location and general condition) to those people. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. We may also release your health information to organizations authorized to handle disaster relief efforts so those who care for you can

receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency.

Workers' Compensation. We may disclose protected health information (PHI) as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

Disclosures Required by HIPAA Privacy Rule. We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting or certain disclosures of PHI about you.

Incidental Disclosures. We may use or disclose PHI incident to a use or disclosure permitted by HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.

Limited Data Set Disclosures. We may use or disclose a limited data set (PHI that has certain identifying information removed) for the purposes of research, public health, or health care operations. This information may only be disclosed for research, public health, and health care operation purposes. The person receiving this information must sign an agreement to protect the information.

NOTE: Except for the situations listed above, we must obtain your written authorization for any other release of your health information. An authorization is different from consent, the primary difference is that unlike with consents, a provider must treat you even if you do not wish to sign an authorization form. If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to HIPAA Privacy Officer, Longest Student Health Center, P O Box 6338, Mississippi State, Mississippi 39762, 662-325-2431.

Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact, HIPAA Privacy Officer, Longest Student Health Center, P O Box 6338, Mississippi State, Mississippi 39762, 662-325-2431. Specifically, you have the right to:

Inspect and copy your health information. With few exceptions, you have the right to inspect and obtain a copy of your health information. For example, this does not apply to psychotherapy notes, or information complied for judicial proceedings. We may charge a fee for a copy of your health information.

Request to amend your health information. If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make this request in writing and give a reason as to why the information should be changed. However, if we did not create the health information that you believe to be incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

Request restrictions on certain uses and disclosures. You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Or, you may wish to limit the health information provided to family or friends involved in your care or payment of medical bills. You may want to limit the health information provided to authorities involved with disaster relief efforts. We are not required to agree to a requested restriction.

If you receive certain medical devices (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number or other identifying information for purposes of tracking the medical device.

As applicable, receive confidential communication of health information. You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special private room or through a written letter sent to a private address. We must accommodate reasonable requests.

Receive a record of disclosures of your health information. In some instances, you have the right to ask for a list of the disclosures of your health information we have made for the previous six years, the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30 day extension, and we may not charge you for the list, unless you request such list more than once per year. Disclosures made to you do not include disclosures for purposes of treatment, payment, health care operations, national security, law enforcement/corrections, and certain health oversight activities.

Obtain a paper copy of this notice. You may request a paper copy of this notice at any time or view it at www.health.msstate.edu/privacy.

Complain. *If you believe your privacy rights have been violated, you may file a complaint with us and with the Federal Department of Health and Human Services. We will not retaliate against you for filing a complaint. To file a complaint with either entity, please contact the* ***HIPAA Privacy Officer, Longest Student Health Center, P O Box 6338, Mississippi State, MS 39762, 662-325-2431, who will provide the necessary assistance and paperwork. This notice of medical information privacy is effective April 14, 2003.***